CHAPTER 1
SECTION 21

HOSPITAL REIMBURSEMENT - BILLED CHARGES SET RATES

ISSUE DATE: August 26, 1985
AUTHORITY: 32 CFR 199.14(a)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

How are billed charges/set rates to be used in determining reimbursement for hospitals?

III. POLICY

A. Billed charges.

In those cases in which the DRG-based payment system or the inpatient mental health per diem payment system is not used, the most common method of reimbursement for covered services of hospitals is that of billed charges. The billed charge is allowable if it is reasonable and is not greater than (1) the charge made to the general public; or (2) the allowed charge applicable to contractor policy-holders (subscribers), when extended to beneficiaries by consent or agreement; or (3) the charge set by local or state regulatory authority as applicable to citizens and extended by law or regulation, consent or agreement to TRICARE.

B. All-inclusive rates.

1. Some providers do not routinely itemize their charges or vary their charges depending upon the various services rendered. Instead, such providers have a set schedule of "all-inclusive" rates which are charged to all patients (or all patients in a given category such as surgical, medical, obstetrical, etc.) regardless of the specific services rendered to each patient. Such rates are based on a per diem or per admission amount and may consist of a single amount for all services or a basic "room and board" charge and a separate set charge for ancillary services. Such all-inclusive rates may be reimbursed so long as they are uniformly charged to all patients and so long as the hospital is incapable of itemizing its bills.

2. Diagnosis-related group (DRG) amounts which hospitals have elected to use in lieu of normal billed charges also qualify as all-inclusive rates. These DRG amounts may be derived from some third-party payer such as Medicare or a Blue Cross plan. Payments based on DRG amounts are authorized only if they are the basis for the hospital's billing--not just the basis for payment by some source.

C. Room charges.

Reimbursement will be at the semi-private room rate unless there are medical indications for a private room.

D. Hospital participation.

1. Participation is required for all hospitals which participate in Medicare, whether they are reimbursed under the DRG-based payment system, the inpatient mental health per diem payment system, or under billed charges/set rates. This also applies to services of hospital-based professionals which are related to inpatient stays.

2. A hospital which is not Medicare-participating and which is exempt from the program's DRG-based payment system and the inpatient mental health per diem payment system may elect to participate on a claim-by-claim basis.

- END -